



DEPARTMENT OF VETERANS AFFAIRS

8320-01

38 CFR Part 4

RIN 2900-AP08

Schedule for Rating Disabilities; Dental and Oral Conditions

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends the Department of Veterans Affairs (VA) Schedule for Rating Disabilities by revising the portion of the schedule that addresses dental and oral conditions. The effect of this action is to ensure that the rating schedule uses current medical terminology and to provide detailed and updated criteria for evaluation of dental and oral conditions for disability rating purposes.

DATES: This final rule is effective on September 10, 2017.

FOR FURTHER INFORMATION CONTACT: Ioulia Vvedenskaya, M.D., M.B.A., Medical Officer, Part 4 VASRD Regulations Staff (211C), Compensation Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420, (202) 461-9700 (This is not a toll-free telephone number).

SUPPLEMENTARY INFORMATION: VA published a proposed rulemaking in the Federal Register at 80 FR 44913 on July 28, 2015, to amend the portion of the VA Schedule of Rating Disabilities (VASRD or rating schedule) dealing with dental and oral conditions. VA provided a 60-day public comment period and interested persons were invited to submit written comments on or before September 28, 2015. VA received 5 comments.

One commenter suggested further defining the description of mandibular and maxillary malunion and maxillary non-union based on the degree of open bite under diagnostic codes 9904 and 9916. However, the severity of mandibular and maxillary displacement and its effect on anterior or posterior open bite depend on an individual's functional anatomy. Therefore, different veterans with the same degree of displacement would present with different degrees of open bite. A qualified dental provider such as a dentist or oral surgeon would appropriately determine the degree of severity in each individual case. Further, rather than basing the severity of open bite on a range of numerical values, it is standard practice for such dental providers to assess the degree of severity as severe, moderate, mild, or not causing open bite.

Additionally, the commenter suggested defining moderate and severe anterior or posterior open bite and mild anterior or posterior open bite. Similarly, due to the variances between individuals' facial anatomy, it would be improper to use exact numerical values to determine the degree of moderate and severe anterior or posterior open bite and mild anterior or posterior open bite. A

qualified dental provider would appropriately measure and record these findings. Therefore, VA makes no changes based on these comments.

The same commenter had a question about why only a 20 percent rating is warranted for severe anterior or posterior open bite due to mandibular malunion and a 30 percent rating is warranted for severe anterior or posterior open bite due to maxillary malunion, while moderate anterior or posterior open bite warrants 10 percent ratings for both conditions. These variations in disability compensation are based on the differences in functional impairment due to maxillary and mandibular fractures. Unlike mandibular fracture and its residuals, maxillary fracture presents a more challenging case for repair and rehabilitation. For example, unlike mandibular fractures, maxillary fractures often communicate with sinuses and/or combine with orbital fractures. Such fractures are predisposed to contamination, sinus infection, and obstruction. Even after following treatment guidelines, significant bony resorption may occur leading to cosmetic contour deformity. Further, although such residuals of maxillary fracture raise the potential for pyramiding, such a situation is addressed by the new note (2) to § 4.150, which directs raters to separately evaluate other impairments under the appropriate diagnostic code. Therefore, the functional impairment due to maxillary fracture significantly differs from mandibular fractures. VA took these functional anatomy differences and the resultant differences in functional impairment into consideration during the revision process.

Additionally, the commenter noted that mandibular malunion and maxillary malunion and non-union do not have the same choices of severity of anterior or posterior open bite. Once more, these differences are based on differences in the functional anatomy of maxillas and mandibles and standard clinical assessments by a qualified dental provider. Therefore, VA makes no changes based on these comments.

Multiple commenters asked for additional guidance in assessing interincisal measurements of maximum unassisted vertical opening under diagnostic code 9905. One commenter stated that guidance was needed on how to handle measurements that fall between the specific numbers. Another commenter suggested adding the phrase “or less” to the whole numbers listed in the proposed rule or using a range of numbers, such as from 21 to 29 millimeters. VA applied a standard scale for the measurement of interincisal ranges, vertical and lateral, based on the Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region by the American Association of Oral and Maxillofacial Surgeons. Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region, American Association of Oral and Maxillofacial Surgeons can be found at <http://www.astmjs.org/impairment.html>. VA agrees that for the sake of clarity, a full range of maximum unassisted vertical opening should be included and makes appropriate edits to diagnostic code 9905.

One commenter stated that VA should address bruxism and its relationship to temporomandibular joint disorder in a note to diagnostic code 9905. Specifically, the commenter stated that VA’s treatment of bruxism as only

a secondary condition and not a stand alone disability is problematic with regards to claims for dental treatment. The commenter recommended amending 38 CFR 3.381 to clarify the treatment of bruxism in regards to service connection for dental treatment or to add to diagnostic code 9905 the phrase “with or without bruxism.” The commenter also recommended rating bruxism as a stand alone issue. However, bruxism is considered a symptom of craniomandibular disorders, of which temporomandibular disorders are a subset; other symptoms of craniomandibular disorders include anxiety, stress, and other mental disorders (Shetty, Shilpa et al., *Bruxism: A Literature Review*, J Indian Prosthodont Soc. 2010 Sep; 10(3): 141–148., <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3081266/>). Therefore, it is not appropriate to place bruxism as a separate diagnosis or a symptom under diagnostic code 9905. VA has determined that only secondary service connection for treatment purposes is warranted for this condition, both because it is only a secondary condition, not a primary condition, and because its symptoms are already contemplated by the underlying condition for which the veteran is being compensated. Thus, it does not require a separate diagnostic code, and VA makes no changes based on this comment.

One commenter had a question about why diagnostic codes 9901, 9908, 9909, 9913, 9914, and 9915 were missing from the discussion. VA did not propose any changes to these diagnostic codes. According to the Federal Register Document Drafting Handbook Rule 1.14, this was noted by inserting

asterisks in place of unchanged diagnostic codes. Therefore, VA makes no changes based on this comment.

The same commenter proposed to rate maxillary and mandibular malunion and non-union exactly the same way, regardless of which bone is affected. However, the functional impairment due to mandibular malunion and non-union significantly differs from maxillary malunion and non-union. VA took these differences in functional anatomy and the resultant differences in functional impairment into consideration during the revision process. Therefore, VA makes no changes based on this comment.

One commenter was supportive of the overall changes and additions to this section of the rating schedule. However, the commenter stated that a service-connected noncompensable rating for a dental disability inappropriately restricts the ability of a recently discharged veteran whose eligibility for outpatient dental services is based on 38 CFR 17.161(b) [Class II] to receive appropriate dental services and appliances. To illustrate, the commenter stated that the dental rating schedule provides for a diagnosis of “loss of teeth, replaceable by prosthesis” with diagnostic code 9913. Because the schedule considers this to be a noncompensable disability, the veteran is limited to receiving one-time treatment for this condition under 38 CFR 17.161(b). The commenter described why this is not a suitable clinical response for the veteran, especially over the veteran’s life-time. Specifically, the commenter stated that the provision of dentures has historically been, and continues to be, VA’s treatment response for this condition, even though (1) modern dentistry, as practiced in the community,

goes beyond this, offering partial dentures, implants, bridges, crowns, and other prostheses, and (2) the use of dentures may be inappropriate and more harmful to the future dental health of the veteran (e.g., where their use, to address a lost tooth, requires the removal of other healthy teeth to fit them). Moreover, this commenter stated that limiting this veteran to one-time treatment for this condition is outdated and a disservice to the veteran, further noting that, even were these newer treatment options available to this cohort, the one-time limitation would still be unreasonable because these newer options typically require replacement after several years. The commenter believes all of these problems would be remedied by either ensuring that this dental condition (diagnostic code 9913) is changed to reflect a compensable rating for veterans who experience complications of treatment, such as inability to load the prosthesis, diminished vocal projection, chronic pain, or peri-implantitis. In the alternative, this particular dental condition/diagnosis could be excepted from the one-time treatment limitation under § 17.161(b). Lastly, this commenter suggested adding a general note under 38 CFR 4.150 to allow for analogous compensable ratings for any dental disabilities service-connected (or treated as service-connected under 38 U.S.C. 1151) which require ongoing treatment.

Veterans with a service-connected compensable dental condition are eligible for any outpatient dental treatment indicated as reasonably necessary to maintain oral health and masticatory function, with no time limits for making application for treatment and no restrictions as to the number of repeat episodes

of treatment under 38 CFR 17.161(a). In addition, other veteran-cohorts are eligible for outpatient dental treatment as specified in § 17.161. Under § 17.161(b) [Class II], a veteran's eligibility for the one-time correction of a service-connected noncompensable dental condition is available to certain veterans who have been recently discharged or released from active service, if specified requirements, including timely filing of the dental application, are met. (No rating action is needed for Class II applicants if the conditions set forth in 38 CFR 17.162 are met).

While we appreciate the arguments raised by the commenter and his advocacy efforts on behalf of the members of his organization, this rulemaking does not seek to revise diagnostic code 9913, as it applies to the loss of teeth, replaceable by prosthesis. As such, these comments go beyond the scope of this rulemaking, which is focused on other codes in the dental rating schedule. Further, a veteran's Class II eligibility for outpatient dental services and applicances is not based on the level of functional impairment for which the Veteran is compensated under 38 CFR part 4. Ratings provided for service-connected conditions under 38 CFR part 4 serve solely to compensate veterans for functional impairment resulting from diseases and injuries and any residuals. In addition, VA has determined that the dental conditions contemplated by § 17.161(b) do not, in general, result in functional impairment. Indeed, VA experts recently carefully considered this very issue as part of an independent undertaking, but they concluded that while such a change would serve a great convenience to affected veterans, no clinical justification exists to

change the non-compensable designation given to conditions under diagnostic code 9913, to include loss of teeth, replaceable by prosthesis. Moreover, the commenter's broader suggested amendments to VA's outpatient treatment dental regulations likewise go beyond the scope of this immediate rulemaking, which again is focused on limited components of the dental rating schedule. Finally, we note that the eligibility criteria set forth in §17.161(b) are based in law, 38 U.S.C. 1712(a)(1)(B), (b), and so cannot be changed via rulemaking. As a result of all these factors, no changes to VA's outpatient dental regulations are made in response to this commenter's comments related to diagnostic code 9913.

The same commenter was supportive of the overall changes and additions to diagnostic codes 9904 and 9916. However, the commenter was concerned about inter-examiner and inter-rater reliability due to the descriptors of open bite, noting that vague descriptors could result in under-evaluation or pyramiding. As discussed above, due to the variances between individuals' facial anatomy, it would be improper to use exact numerical values to determine the degree of moderate and severe anterior or posterior open bite and mild anterior or posterior open bite. Further, the potential for pyramiding is addressed by the new note (2) to § 4.150, which directs raters to separately evaluate other impairments under the appropriate diagnostic code. Additionally, VA took differences in functional anatomy of maxillas and mandibles into consideration during the revision process. Therefore, VA makes no changes based on this comment.

One commenter urged VA to include periodontal disease as a compensable condition and amend 38 CFR 3.381 accordingly. The commenter stated that periodontal disease has been linked to diabetes as well as other conditions, and veterans who have service-connected diabetes as a result of herbicide exposure are not able to receive dental treatment unless their overall disability rating is 100 percent. The commenter stated that assigning a compensable disability rating for periodontal disease or providing for a compensable rating as a secondary disability associated with service-connected diabetes would alleviate the lack of treatment issue for veterans. As noted previously, the ratings under 38 CFR part 4 serve to compensate for functional impairment. VA has determined that periodontal disease does not result in loss of earning capacity resulting from functional impairment, so no changes have been made to make this condition compensable. Therefore, VA makes no changes based on these comments.

VA is correcting typographical errors under DC 9905 and DC 9916. With respect to DC 9905, in the proposed rulemaking notice, for the 50 percent evaluation, VA referred to mechanically altered food instead of mechanically altered foods. With respect to DC 9916, in the explanatory note for disability rating personnel, VA failed to include the phrase “following treatment” between “maxilla fragments” and the parenthetical. VA is correcting these errors in this final rule.

VA appreciates the comments submitted in response to the proposed rulemaking notice. Based on the rationale stated in the proposed rulemaking notice and in this document, the final rule is adopted with the changes noted.

#### Effective Date of Final Rule

Veterans Benefits Administration (VBA) personnel utilize the Veterans Benefit Management System for Rating (VBMS-R) to process disability compensation claims that involve disability evaluations made under the VASRD. In order to ensure that there is no delay in processing veterans' claims, VA must coordinate the effective date of this final rule with corresponding VBMS-R system updates. As such, this final rule will apply effective September 10, 2017, the date VBMS-R system updates related to this final rule will be complete.

#### Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a "significant regulatory action," requiring review by the Office of Management and

Budget (OMB), unless OMB waives such review, as “any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in this Executive Order.”

The economic, interagency, budgetary, legal, and policy implications of this final rule have been examined, and it has been determined not to be a significant regulatory action under Executive Order 12866. VA’s impact analysis can be found as a supporting document at <http://www.regulations.gov>, usually within 48 hours after the rulemaking document is published. Additionally, a copy of this rulemaking and its impact analysis are available on VA’s Web site at <http://www.va.gov/orpm/>, by following the link for “VA Regulations Published From FY 2004 Through Fiscal Year to Date.”

#### Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. This final rule will not affect any

small entities. Only certain VA beneficiaries could be directly affected.

Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

#### Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

#### Paperwork Reduction Act

This final rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3521).

### Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.009, Veterans Medical Care Benefits; 64.104, Pension for Non-Service-Connected Disability for Veterans; 64.109, Veterans Compensation for Service-Connected Disability; and 64.110, Veterans Dependency and Indemnity Compensation for Service Connected Death.

### Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Gina S. Farrisee, Deputy Chief of Staff, Department of Veterans Affairs, approved this document on July 21, 2017, for publication.

Dated: July 27, 2017.

---

Michael Shores,  
Director, Regulation Policy & Management,  
Office of the Secretary,  
Department of Veterans Affairs.

List of Subjects in 38 CFR Part 4

Disability benefits, Pensions, Veterans.

For the reasons set out in the preamble, VA amends 38 CFR part 4 as follows:

PART 4--SCHEDULE FOR RATING DISABILITIES

1. The authority citation for part 4 continues to read as follows:

Authority: 38 U.S.C. 1155, unless otherwise noted.

Subpart B--Disability Ratings

2. Amend § 4.150 by:

- a. Adding Notes 1 and 2 at the beginning of the table;
- b. Revising the entries for diagnostic codes 9900 and 9902 through 9905;
- c. Removing the entries for diagnostic codes 9906 and 9907;
- d. Revising the entry for diagnostic code 9911;
- e. Removing entry for diagnostic code 9912;
- f. Revising the entry for diagnostic code 9916; and
- g. Adding, in numerical order, entries for diagnostic codes 9917 and 9918.

The revisions and additions read as follows:

§ 4.150 Schedule of ratings—dental and oral conditions.

	Rating
Note (1): For VA compensation purposes, diagnostic imaging studies include, but are not limited to, conventional radiography (X-ray), computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET),	

radionuclide bone scanning, or ultrasonography.		
Note (2): Separately evaluate loss of vocal articulation, loss of smell, loss of taste, neurological impairment, respiratory dysfunction, and other impairments under the appropriate diagnostic code and combine under § 4.25 for each separately rated condition.		
9900 Maxilla or mandible, chronic osteomyelitis, osteonecrosis or osteoradionecrosis of: Rate as osteomyelitis, chronic under diagnostic code 5000.		
* * * *		* * *
9902 Mandible, loss of, including ramus, unilaterally or bilaterally: Loss of one-half or more, Involving temporomandibular articulation.		
Not replaceable by prosthesis.....		70
Replaceable by prosthesis.....		50
Not involving temporomandibular articulation.		
Not replaceable by prosthesis .....		40
Replaceable by prosthesis.....		30
Loss of less than one-half, Involving temporomandibular articulation.		
Not replaceable by prosthesis.....		70
Replaceable by prosthesis.....		50
Not involving temporomandibular articulation.		
Not replaceable by prosthesis .....		20
Replaceable by prosthesis.....		10
9903 Mandible, nonunion of, confirmed by diagnostic imaging studies:		
Severe, with false motion.....		30
Moderate, without false motion.....		10
9904 Mandible, malunion of:		
Displacement, causing severe anterior or posterior open bite.....		20
Displacement, causing moderate anterior or posterior open bite...		10
Displacement, not causing anterior or posterior open bite.....		0
9905 Temporomandibular disorder (TMD): Interincisal range:		
0 to10 millimeters (mm) of maximum unassisted vertical opening.		
With dietary restrictions to all mechanically altered foods		50
Without dietary restrictions to mechanically altered foods.....		40

11 to 20 mm of maximum unassisted vertical opening. With dietary restrictions to all mechanically altered foods.....	40
Without dietary restrictions to mechanically altered foods.....	30
21 to 29 mm of maximum unassisted vertical opening. With dietary restrictions to full liquid and pureed foods.....	40
With dietary restrictions to soft and semi-solid foods.....	30
Without dietary restrictions to mechanically altered foods.....	20
30 to 34 mm of maximum unassisted vertical opening. With dietary restrictions to full liquid and pureed foods.....	30
With dietary restrictions to soft and semi-solid foods.....	20
Without dietary restrictions to mechanically altered foods.....	10
Lateral excursion range of motion: 0 to 4 mm.....	10
Note (1): Ratings for limited interincisal movement shall not be combined with ratings for limited lateral excursion.	
Note (2): For VA compensation purposes, the normal maximum unassisted range of vertical jaw opening is from 35 to 50 mm.	
Note (3): For VA compensation purposes, mechanically altered foods are defined as altered by blending, chopping, grinding or mashing so that they are easy to chew and swallow. There are four levels of mechanically altered foods: full liquid, puree, soft, and semisolid foods. To warrant elevation based on mechanically altered foods, the use of texture-modified diets must be recorded or verified by a physician.	
* * * *	* * *
9911 Hard palate, loss of:	
Loss of half or more, not replaceable by prosthesis.....	30
Loss of less than half, not replaceable by prosthesis.....	20
Loss of half or more, replaceable by prosthesis.....	10
Loss of less than half, replaceable by prosthesis.....	0
* * * *	* * *
9916 Maxilla, malunion or nonunion of:	
Nonunion,	
With false motion.....	30
Without false motion.....	10

Malunion, With displacement, causing severe anterior or posterior open bite.....	30
With displacement, causing moderate anterior or posterior open bite.....	10
With displacement, causing mild anterior or posterior open bite.....	0
Note: For VA compensation purposes, the severity of maxillary nonunion is dependent upon the degree of abnormal mobility of maxilla fragments following treatment (i.e., presence or absence of false motion), and maxillary nonunion must be confirmed by diagnostic imaging studies.	
9917 Neoplasm, hard and soft tissue, benign: Rate as loss of supporting structures (bone or teeth) and/or functional impairment due to scarring.	
9918 Neoplasm, hard and soft tissue, malignant.....	100
Note: A rating of 100 percent shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals such as loss of supporting structures (bone or teeth) and/or functional impairment due to scarring.	

3. Amend appendix A to part 4 by:

- a. Revising the entries for diagnostic codes 9900, 9902, and 9903;
- b. Adding, in numerical order, an entry for diagnostic code 9904;
- c. Revising the entry for diagnostic code 9905;
- d. Adding, in numerical order, entries for diagnostic codes 9906, 9907, 9911,  
and 9912;
- e. Revising the entry for diagnostic code 9916; and

f. Adding, in numerical order, entries for diagnostic codes 9917 and 9918.

The revisions and additions read as follows:

APPENDIX A TO PART 4—TABLE OF AMENDMENTS AND EFFECTIVE DATES SINCE 1946

Sec.	Diagnostic Code No.	
* * *	* * *	*
	9900	Criterion September 22, 1978; criterion February 17, 1994; title September 10, 2017.
	* * *	* * * *
	9902	Criterion February 17, 1994; evaluation September 10, 2017; title September 10, 2017.
	9903	Criterion February 17, 1994; evaluation September 10, 2017; title September 10, 2017.
	9904	Criterion September 10, 2017.
	9905	Criterion September 22, 1978; evaluation February 17, 1994; evaluation September 10, 2017; title September 10, 2017.
	9906	Removed September 10, 2017.
	9907	Removed September 10, 2017.
	* * *	* * * *
	9911	Criterion and title September 10, 2017.
	9912	Removed September 10, 2017.
	* * *	* * * *
	9916	Added February 17, 1994; criterion September 10, 2017.
	9917	Added September 10, 2017.
	9918	Added September 10, 2017.

4. Amend appendix B to part 4 by:

- a. Revising the entries for diagnostic codes 9900, 9902, 9903, and 9905;
- b. Removing the entries for diagnostic codes 9906 and 9907;
- c. Revising the entry for diagnostic code 9911;

- d. Removing the entry for diagnostic code 9912; and
- e. Adding, in numerical order, entries for diagnostic codes 9917 and 9918.

The revisions and additions read as follows:

#### APPENDIX B TO PART 4-NUMERICAL INDEX OF DISABILITIES

Diagnostic Code No.	
* * *	* * * *
DENTAL AND ORAL CONDITIONS	
9900.....	Maxilla or mandible, chronic osteomyelitis, osteonecrosis, or osteoradionecrosis of.
* * *	* * * *
9902.....	Mandible loss of, including ramus, unilaterally or bilaterally.
9903.....	Mandible, nonunion of, confirmed by diagnostic imaging studies.
* * *	* * * *
9905.....	Temporomandibular disorder (TMD).
* * *	* * * *
9911.....	Hard palate, loss of.
* * *	* * * *
9917.....	Neoplasm, hard and soft tissue, benign.
9918.....	Neoplasm, hard and soft tissue, malignant.

5. Amend appendix C to part 4 as follows:

- a. Under the entry for “Limitation of motion,” remove the entry for  
“Temporomandibular articulation” and add in its place an entry for  
“Temporomandibular”;
- b. Under the entry for “Loss of,” add in alphabetical order an entry for “Palate,  
hard”;

- c. Revise the entry for “Mandible”;
- d. Add in alphabetical order an entry for “Maxilla or mandible, chronic osteomyelitis, osteonecrosis, or osteoradionecrosis of”;
- e. Remove the entries for “Palate, hard” and “Ramus” located below the entry for “Nose, part of, or scars” and above the entry for “Skull, part of”;
- f. Under the entry for “Neoplasms,” under both “Benign” and “Malignant,” add in alphabetical order an entry for “Hard and soft tissue”;
- g. Under the entry for “Nonunion,” remove the entry for “Mandible” and add in its place an entry for “Mandible, confirmed by diagnostic imaging studies”;
- h. Remove the entry for “Osteomyelitis maxilla or mandible”.

The additions and revisions read as follows:

#### APPENDIX C TO PART 4-ALPHABETICAL INDEX OF DISABILITIES

	Diagnostic Code No.
* * * *	* * *
Limitation of motion:	
* * * *	* * *
Temporomandibular.....	9905
* * * *	* * *
Loss of:	
* * * *	* * *
Palate, hard.....	9911
* * * *	
Mandible:	

